STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012107	A. BUILDING: _____ B. WING _____	12/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODVIEW ASSISTED LIVING	3320 E STATE BLVD FORT WAYNE, IN 46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: December 28, & 29, 2015 Facility number: 012107 Provider Number: 012107 AIM number: N/A Census bed type: Residential: 81 Total: 81 Census payor type: Other: 81 Total: 81 Sample: Residential sample: 7 Woodview Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. QR completed on December 30, 2015 by 17934.	R 000		